DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

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DURABLE MEDICAL EQUIPMENT (DME)
CPAP & BIPAP BULLETIN

CONTENTS

Effective November 1, 2005, **continuous rental** for CPAP or BiPAP S devices will no longer be reimbursed for recipients for which the device is covered. These devices will be reimbursed on a rent-to-purchase basis. Both purchase and rental reimbursement rates have been established, as have reimbursement rates and quantity limitations for supplies. Initial prior authorizations will be reviewed and approved for three (3) months. Prior authorization may be requested for an additional nine (9) months with documentation that the recipient is compliant in using the device.

Any CPAP or BiPAP S device that has currently been rented by Medicaid for twelve (12) or more months is considered purchased. No further rental payments will be made and providers may only bill for supplies and repairs needed for continued use after the initial twelve (12) month rental period.

If there is discontinuation of usage of the CPAP or BiPAP S device at any time, the provider is expected to stop billing for the equipment and related accessories and supplies.

COVERAGE FOR CPAP DEVICES (E0601)

A single level CPAP device (E0601) is covered if the patient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and is prior authorized. A copy of the polysomnogram must be submitted with the Prior Authorization Request (PAR) form and the information provided must meet either of the following criteria.

1) The Apnea Hypopnea Index, (AHI) is greater than or equal to 15 events per hour; or,

2) The AHI is from 5 to 14 events per hour with documented symptoms of:

   a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,

   b) Hypertension, ischemic heart disease, or history of stroke.

Polysomnographic studies must be performed in a facility-based sleep study laboratory and not in the home or may not be performed by a DME provider. Portable multi-channel home sleep testing devices are also not acceptable.

CONTINUED COVERAGE FOR CPAP BEYOND THE FIRST THREE (3) MONTHS (E0601KJ)

Continued coverage for a CPAP device beyond the first three (3) months of therapy requires that, no sooner than the 61st day after initiating therapy, the DME provider ascertain from either the recipient or the treating physician that the recipient is continuing to use the CPAP device. This information must be documented on the PAR form and procedure code E0601 with the modifier KJ, must be used.

If the above criteria is not met, continued rental coverage of the device will not be approved.

COVERAGE FOR RESPIRATORY ASSIST DEVICES, BIPAP S, (E0470)

The "treating physician" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices. Physicians who treat patients for other medical conditions may or may not be so qualified, and if not, though they may be the treating physician of the recipient for other conditions, they are not considered the "treating physician" for the administration of noninvasive positive pressure respiratory assistance, (NPPRA) therapy.

The PAR form must provide evidence from the treating physician symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc, in addition to a copy of the polysomnogram.

A respiratory assist device (E0470) is covered for those recipients with clinical disorder groups characterized as (I) restrictive thoracic disorders), (II) severe chronic obstructive pulmonary disease (COPD), (III) central sleep apnea (CSA), or (IV) obstructive sleep apnea (OSA) and who also meet the following criteria:

I) Restrictive Thoracic Disorders:

A) Documentation must be provided with the PAR form that the recipient has a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB), and

B)
1) An arterial blood gas PaCO2, done while awake and breathing the patient's usual FIO2 is greater than or equal to 45 mm Hg, or

2) Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the patient's usual FIO2, or,

3) For a progressive neuromuscular disease (only), maximal inspiratory pressure is less than 60 cm H20 or forced vital capacity is less than 50% predicted, and

C) Chronic obstructive pulmonary disease does not contribute significantly to the patient's pulmonary limitation.

II) Severe COPD:

A)
1) An arterial blood gas PaCO2, done while awake and breathing the patient's usual FIO2, is greater than or equal to 52 mm Hg, and

2) Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO2 (whichever is higher), and

B) Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out.

III) Central Sleep Apnea (CSA), i.e., apnea not due to airway obstruction:

Prior to initiating therapy, a complete facility-based, polysomnogram must be performed documenting the following:

A) The diagnosis of central sleep apnea (CSA), and

B) The exclusion of obstructive sleep apnea (OSA) as the predominant cause of sleep-associated hypoventilation, and

C) The ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation, and

D) Oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the patient's usual FIO2, and

E) Significant improvement of the sleep-associated hypoventilation with the use of a E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the patient's usual FIO2

IV) Obstructive Sleep Apnea (OSA):

Criteria (A) and (B) are both met:

A) A complete facility-based, polysomnogram, has established the diagnosis of obstructive sleep apnea according to the following criteria:

1) The apnea-hypopnea index (AHI) is greater than or equal to 15 events per hour, or

2) The AHI is from 5 to 14 events per hour with documented symptoms of:

a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or

b) Hypertension, ischemic heart disease, or history of stroke, and

B) A single level device (E0601, Continuous Positive Airway Pressure Device, CPAP) has been tried and proven ineffective.

Polysomnographic studies must be performed in a facility-based sleep study laboratory and not in the home or may not be performed by a DME provider. Portable multi-channel home sleep testing devices are also not acceptable.

CONTINUED COVERAGE FOR BiPAP S BEYOND FIRST THREE (3) MONTHS (E0470KJ)

Continued coverage for a BiPAP S device beyond the first three (3) months of therapy requires that, no sooner than the 61st day after initiating therapy, the DME provider ascertain from either the recipient or the treating physician that the recipient is continuing to use the BiPAP device. The information must be documented on the PAR form for continuation of coverage beyond three (3) months: Procedure code E0470 with the modifier KJ, must be used.

A signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the patient is compliantly using the device (an average of 4 hours per 24 hour period) and that the patient is benefiting from its use must be submitted with the PAR form.

If the above criteria is not met, continued coverage of a E0470 device will be denied as not medically necessary.

CPAP AND BIPAP S SUPPLIES

Either a non-heated or a heated humidifier is covered separately when ordered by the treating physician and prior authorized for use with a covered CPAP or BiPAP S device. The PAR form must indicate that the humidifier is being used in conjunction with a CPAP or BiPAP S device. For those devices that have previously reached purchase price through rental payments, a humidifier may not be billed without justification submitted on the PAR form that any previously dispensed humidifier is no longer working properly. Providers should request the purchase (NU) of the humidifier at the same time as the CPAP or BiPAP S device.

Supplies used with a CPAP or BiPAP S device are covered when the coverage criteria for the device is met. If the coverage criteria is not met, the supplies will also be denied. The following table represents the Medicaid maximum allowed reimbursement amount and the quantity limitations. Supplies, repair and maintenance are included in the first twelve (12) months of rental reimbursement and are not paid for separately. Providers must not just dispense supplies because the quantity limitations allow it. The recipient must agree that replacement of supplies is desired and necessary, no automatic shipping of supplies is allowed.

Billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, in the absence of documentation clearly explaining the medical necessity of the excess quantities, will be denied as not medically necessary. A paper Medical Necessity form must be submitted with the claim form for supplies in excess of those allowed.

CPAP AND BiPAP SUPPLIES & EQUIPMENT

CODE	MODIFIER	DESCRIPTION	QUANTITY LIMITATIONS	MEDICAID ALLOWED AMOUNT	REIMBURSE-MENT GUIDELINES
A7030	NU	FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH	1 per 24 months	$188.64	MNF
A7031	NU	FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH	1 per 6 months	$ 69.77	MNF
A7032	NU	REPLACEMENT CUSHION FOR NASAL APPLICATION DEVICE, EACH	1 per 6 months	$ 40.53	MNF
A7033	NU	REPLACEMENT PILLOWS FOR NASAL APPLICATION DEVICE, PAIR	1 pair per 6 months	$ 28.41	MNF
A7034	NU	NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP	1 per 24 months	$117.64	MNF
A7035	NU	HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE	1 per 6 months	$ 39.75	MNF
A7036	NU	CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE	1 per 6 months	$ 18.20	MNF
A7037	NU	TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE	1 per 24 months	$ 41.02	MNF
A7038	NU	FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	2 per month	$ 5.39	MNF
A7039	NU	FILTER, NON-DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	1 per 12 months	$ 15.33	MNF
A7044	NU	ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH	1 per 6 months	$120.91	MNF
A7045	NU	EXHALATION PORT WITH OR WITHOUT SWIVEL USED WITH ACCESSORIES FOR POSITIVE AIRWAY DEVICES, REPLACEMENT ONLY	1 per 6 months	$ 19.47	MNF
A7046	NU	WATER CHAMBER FOR HUMIDIFIER, USED WITH POSITIVE AIRWAY PRESSURE DEVICE, REPLACEMENT, EACH		$ 19.51	MNF
E0561	NU	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE		$107.00	PA
E0562	NU	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE		$301.22	PA
E0601	RR	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE	(1ST 3 months)	$105.00	PA & Polysomno-gram

CODE	MODIFIER	DESCRIPTION	QUANTITY LIMITATIONS	MEDICAID ALLOWED AMOUNT	REIMBURSE-MENT GUIDELINES
E0601	RR KJ	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE	(Additional 9 months)	$105.00	PA
E0470	RR	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE USED WITH NON-INVASIVE INTERFACE	(1st 3 months)	$256.00	PA & Polysomno-gram
E0470	RR KJ	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK0UP RATE FEATURE USED WITH NON-INVASIVE INTERFACE	(Additional 9 months)	$256.00	PA

Provider Bulletins are available on the DMS Website at http://www.dss.mo.gov/dms/pages/bulletins.htm. Bulletins will remain on the Published Bulletin site only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896